Discharges Against Medical Advice
Provider Accountability and
Psychiatric Patients’ Rights

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Until recent decades, humane treatment and legal protection for the rights of individuals with mental illness had not been a priority. Before the middle of this century, persons with mental illness (and sometimes those who were sane) could be confined indefinitely and against their will in deplorable environments. Abuse and inappropriate treatment were inflicted upon this group of individuals until activists began to promote legislation and develop laws that would guarantee their constitutional rights and insure treatment or appropriate release.

During recent years, emphasis on patients’ rights and least-restrictive-treatment philosophy have increased. Several court cases have set precedents for false imprisonment and assault and battery charges involving both voluntary and committed patients.

One issue that continues to plague facilities that treat psychiatric patients is the against medical advice (AMA) dilemma. When a voluntary patient wishes to exercise the constitutional guarantee of liberty and leave the facility, clinicians may be placed in the difficult predicament of weighing provider accountability for the patient’s safety against that of the patient’s right to refuse treatment.

Competency and Safety
Two key clinical components must be considered: competency and safety. A competent patient who poses no threat to self or others may not be prevented from leaving the facility, but the often complicated factors surrounding irregular discharges present clinical and legal challenges. Future trends, such as changing insurance benefits and home care, may further complicate the AMA issue for psychiatric patients.

Throughout history, people have been afflicted with mental illness, and societies have struggled with ways to manage their symptoms and the problems those symptoms create. But only within the past few decades has a plethora of laws, statutes, and legal issues created such an impact on the evolving practice of psychiatric and mental health care.

In the United States, 1.6 million psychiatric admissions occur each year; of that number, 73% are admitted on a voluntary basis (Simon, 1992). In addition, psychiatric patients can be found in other health care settings, particularly in emergency departments and community clinics. A wide spectrum of age groups is represented, and nurses practicing in a variety of clinical settings must understand the basic legal issues involved when one of these patients decides to refuse treatment or to leave the facility against medical advice.

Most states have explicit protocols designed to commit patients involuntarily when they represent a danger to themselves or others. Although questions may still arise regarding these involuntary treatment protocols, an even more complex set of circumstances can come into play when a voluntary psychiatric patient decides to leave a facility against medical advice. What may seem on the surface to be an individual simply exercising the constitutional guarantee of liberty may, in fact, be an issue complicated by worries about provider liability, legitimate concerns about the patient’s safety, and even institutional politics.

Dalrymple and Fata (1993) report that between 6% and 35% of voluntary psychiatric admissions terminate with an AMA discharge, indicating that this phenomenon warrants exploration. Reasons vary, but certain diagnoses are more commonly associated with AMA discharges: notably, patients with substance abuse problems (Endicott & Watson, 1994); and those with certain personality disorders (Greenberg & Otero, 1994). In addition, patient awareness regarding constitutional rights issues has increased in recent years, along with a trend in clinical practice toward least-restrictive-treatment protocols.

Sometimes, requests to leave AMA are handled easily by skilled clinicians who effectively problem solve patient complaints or screen those patients who are clearly a danger to themselves or others, and detention protocols are initiated. But frequently, when a patient with a history of impulsivity or unsafe behavior decides to leave AMA, the situation may escalate to a level of uncertainty on the part of clinicians, resulting
in an angry patient who believes their personal freedom is being jeopardized.

A voluntary psychiatric patient who wishes to exercise the constitutional guarantee of liberty can place clinicians and treatment facilities in the difficult position of deciding between concerns about the patient’s safety and the patient’s right to refuse treatment.

Legal issues

In psychiatry, as in other health care specialties, the threat of malpractice lawsuits has increased, and among psychiatric patients, most lawsuits involve suicide cases (Simon, 1992). For this reason, it is particularly important for clinicians to weigh risks carefully when patients with a history of suicidal ideation request to leave AMA.

False imprisonment

A voluntary patient who poses no threat to self or others, however, may have grounds for a false imprisonment lawsuit if the hospital does not permit discharge. One of the earliest and most interesting cases is described in Cook v. Highland Hospital (1915) in which the Supreme Court of North Carolina found that “Where a patient in a sanitarium, who was not in such condition that she would be likely to imperil her health or safety, desired to leave, those in charge of the sanitarium cannot lawfully compel her to remain.”

The court also ruled that just because a patient voluntarily signs admission papers and agrees to the rules of the institution, he or she does not relinquish control and the ability to decide to leave. This landmark case continues to be cited in today’s current literature. Even an involuntary patient who can live safely outside the hospital may not be further detained, according to a court decision in O’Connor v. Donaldson (1975).

If hospitals have vague or ambiguous policies on AMA discharges, or if protocols have evolved that are not based on legal statutes and case law, nurses may find themselves preventing discharge because of uncertainty and fear, and may not have the tools or the support to make appropriate judgments when a patient requests to leave.

Of course, in cases where the patient is floridly psychotic or threatening harm to self or others, the decision may be made by the nurse to prevent a patient from leaving AMA, and this decision is clinically sound and legal. In Gonzales v. New York (1983), the court found that the “right to detain a person who poses an imminent threat to himself exists at common law.” In addition, most states’ statutes provide clearly defined protocols for initiating detention proceedings to continue confinement against a patient’s will.

False imprisonment, however, is defined by Aiken & Catalano (1989) as “the unlawful intentional confinement of another within fixed boundaries so that the confined person is conscious of the confinement or harmed by it. The restraints used to confine another may be chemical, physical, or emotional, that is, intimidation.” Clearly, it is essential to assess the patient and to make a decision whether to release or follow legal detention protocols. When delays occur, power struggles may ensue, and these only serve to escalate the conflict. There are many reasons for these delays in an inpatient setting.

“Holding” a patient

Physicians often are not present when the patient asks to leave. Nurses usually make an attempt to reach the physician, and this may take time. Sometimes a physician may disagree with the patient’s request, believing the patient is, indeed, unsafe, and the doctor may ask nursing staff to “hold” the patient.

Sometimes, AMA requests happen at inconvenient times: change of shift, middle of the night, or during a disturbance in the milieu. Nurses should be familiar with their own state laws; some provide a short time period in which it is legal to “hold” a patient without initiating detention proceedings, while these circumstantial details are addressed. These “grace” periods may range from 2 to 8 hours, which should allow ample time to contact a physician or arrange proper support and follow up for the patient after discharge.

Some hospitals want all patients leaving AMA to have a physician’s order for AMA discharge, and in these cases, it becomes imperative that physicians, too, understand the law and the importance of following statutes for detention if they strongly disagree with the patient’s request to leave. Nurses should never be placed in the position of having to “hold” a patient illegally. All clinicians in the psychiatric setting should be aware that “disregard of a competent mental health patient’s wishes may constitute assault and battery” (Aiken & Catalano, 1994).

Coercion attempts

Occasionally, when voluntary patients request to leave against medical advice, physicians may threaten to initiate detention proceedings as a way to coerce them into staying. Beauchamp and Childress (1989) define coercion as occurring when “one person intentionally uses a credible and severe threat of harm or force to control another.”

Clinicians must be cautioned, however, in using threats of commitment to control patients or to bring about treatment compliance. Unless such action is justified, these threats may be grounds for a lawsuit (Simon, 1992). In Hapgood v. Biloxi Regional Medical Center (1989), questions were raised as to whether the hospital followed statutory...
commitment procedures appropriately. Threats of detention should not be made unless clinicians believe the patient is a danger to self or others; proper protocols must then be initiated without engaging the patient in a power struggle.

**The use of restraints**

Occasionally, disputes between staff and patients over discharge issues may result in actions that go beyond verbal interventions. Even patients who have no previous history of violence may become so angry when held against their will that they may punch a wall or exhibit other manifestations of rage.

It is at these times that decisions are made to use physical restraint to continue the confinement. This decision is, indeed, legally risky if detention protocols have not been initiated. Extreme caution must be used when considering physical restraints to hold nondangerous voluntary patients against their will.

The major guideline for the use of restraints is “only to prevent serious harm to the patients or others in the immediate environment” (Laben & Powell, 1984). Any other use of restraints may violate state statutes, interfere with constitutional protections, violate accreditation recommendations, and also may result in civil liability (Simon, 1992). In *Maben v. Rankin* (1961), the court ruled “to the extent that force is used to accomplish unlawful detention of a person in a mental institution in violation of statute, there is liability for assault and battery.”

Physical restraint should never be used to end a power struggle between a patient and a physician. Seclusion may be a manifestation of the dynamics of the ward, for example, when staff inappropriately seclude a particular patient as an attempt to enlist and involve a physician who maintains an aloof, distant, and contemptuous attitude (Tardiff, 1984).

**Applications to Clinical Practice and Solutions**

Reasons for AMA discharges vary. Sometimes patients, particularly those with substance abuse problems, simply decide that sobriety is too difficult and wish to return to their previous lifestyle. They may be experiencing uncomfortable withdrawal symptoms. Others may have family concerns, such as young children, that take priority over an inpatient stay. Some simply tire of the confining milieu. Competent adult psychiatric patients are capable of setting their own treatment goals and may disagree that lengthy participation in the therapeutic milieu is necessary. Others dislike group work.

Financial reasons also contribute to other claims that the patients were “hospitalized solely to extract the maximum amount of money available under their insurance policy” (McDonald, 1994).

**Necessary assessments**

To avoid the legal problems that may result when voluntary psychiatric patients request to leave a facility AMA, clinicians must be able to assess competency; and assess the patient’s danger to self or others.

Other clinical issues include:
- the utilization of early intervention to avoid AMA discharges;
- good communication between physicians and staff;
- understanding of least-restrictive-treatment philosophy;
- sound documentation; and
- the use of appropriate AMA forms.

**Avoidance of AMA Discharges**

Although no facility can avoid all requests to leave AMA, some of the requests can be avoided by appropriate clinical interventions. First, administrators, nursing staff, and physicians must be aware of today's changing health care environment, which necessitates rapid assessment and stabilization of symptoms. Extended hospital stays to increase hospital profit without measurable treatment progress can be wasteful of a patient’s resources and are ethically questionable. Physicians, nurses, and social workers should maintain good communication that centers on optimal patient care—assessment and stabilization of symptoms and good discharge planning.

Sometimes patients have minor complaints that escalate into AMA requests. Early interventions in responding to these complaints often can resolve those problems. Some hospitals find it useful to have one employee in a patient advocate role to serve as an objective third party to help negotiate treatment issues that are becoming problematic.

In addition, appropriate patient education can clarify treatment goals and help the patient develop realistic expectations.
of an inpatient stay. Patients should be involved in formulating their own goals and planning their discharge supports.

**Substance abuse patients**

Patients being treated for substance abuse present unique AMA-risk issues. Of intravenous drug abusers, between 30% and 50% have AIDS, and discharge before treatment is finished can lead to more risky behavior that may endanger others (Endicott & Watson, 1994). In addition, higher mortality rates were reported in a study by Corley and Link (1981) in the 6 months following AMA discharges from a Veterans Administration hospital. The patients who left AMA were significantly more likely to have histories that included alcoholism. Endicott & Watson (1994) found that patient education and properly titrated medication for withdrawal symptoms were among several factors that significantly reduced the number of AMA discharges on an in-patient substance abuse unit.

Understanding of Least-Restrictive-Philosophy

In recent years, a great deal of attention has been given to a philosophy of treatment that utilizes the least restrictive methods of treatment for psychiatric patients. Laben & Powell (1989) cites findings from O'Connor v. Donaldson in which the Supreme Court ruled that “one cannot constitutionally be confined if other less restrictive alternatives are more suitable and if the person has a support system and is capable of surviving safely in the community.” The concept of least restrictive means “providing sufficient care for the client with the least restrictive methods in the least restrictive setting” (Laben & Powell, 1989). These settings may include partial hospitalization, day-treatment programs, halfway houses, or home care.

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Sometimes simply validating a patient’s wishes to leave and asking the individual to participate actively in planning for follow-up treatment in a less restrictive environment will provide the patient with a sense of control in health care decisions and will pave the way for a safe and therapeutic discharge. Skillful physicians and experienced nursing staff know that this is highly preferable to engaging patients in conflicts over discharge issues.

**Documentation and AMA Forms**

Sometimes, however, despite therapeutic interventions and appropriate treatment planning, AMA discharge requests cannot be prevented. In all irregular discharge circumstances, proper documentation is essential. When a voluntary psychiatric patient requests to leave AMA, the nurse’s responsibility includes not only an appropriate clinical response but thorough and accurate documentation. Aiken & Catalano (1994) recommend that documentation of AMA requests should include:

- The mental status of the patient requesting to leave;
- The content of conversation in which patient gives reasons for wanting to leave (in the patient’s own words);
- Content of discussions in which possible risks of leaving were described to the patient;
- Instructions on medications and follow-up care;
- Conversations with significant others who may be present; and
- Destination of the patient and method of transportation.

In addition, it is advisable to record attempts made to contact the patient’s physician. If the doctor cannot be reached to give a verbal AMA discharge order, the legality of “holding” the patient may come into question. Hospital management teams should be knowledgeable about the legal issues described previously and should provide in-house or on-call supervisors who can assist staff in resolving irregular discharge questions without jeopardizing patients’ rights or causing provider liability.

**AMA forms**

An AMA form developed by the hospital’s attorney should be available for the patient to sign. Sucha (1992) suggested that the form include an informed consent to refuse treatment and an indication that the facility has offered to provide the treatment it believes necessary to stabilize symptoms. AMA forms should also include a signed statement that the patient is leaving against medical advice and understands that doing so could threaten life, well-being, or medical safety. The form must be dated, timed, and witnessed.

If the patient refuses to sign an AMA form, staff must document reasons for the refusal in the patient’s record.

**Assessment of Competency and Safety**

Regardless of documentation or signed forms, the key factors in deciding to release a voluntary psychiatric patient are:

- assessment of competency; and
- assessment of potential danger to self or others.

**Competency**

To refuse treatment, an individual must be competent to do so. “The courts, while supporting patients’ rights to refuse recommended medical treatment, have found physicians negligent when they complied with an incompetent patient’s refusal to receive treatment” (Searight, 1992).

However, merely being a psychiatric patient does not imply incompetency. “Regardless of the differences in state law, it is particularly important to remember that unless a person has been declared
incompetent prior to or at the time of admission to the facility, he maintains the civil rights of any citizen” (Laben & Powell, 1984).

Simon (1992) has thoroughly explored this issue and further explains that “mental disability or illness (e.g., psychosis) does not, in and of itself, render a person incompetent or incompetent in all areas of functioning.”

Many states’ statutes are explicit on the issue of competency. For example, the Virginia Code provides a definition of “legally incompetent”: “Legally incompetent means a person who has been adjudicated incompetent by a circuit court because of a mental condition which renders him incapable of taking care of his person or handling and managing his estate” (6 Va. Stat. § 37.1-128.01).

If staff believes the patient is incompetent, proper detention procedures must be initiated to hold the patient against the individual’s will so that a judge can rule on the incompetency and decide whether to continue the confinement. In Plumadore v. New York (1980), the court awarded $40,000 to the claimant for false imprisonment and the Supreme Court, Appellate Division, held that “where no proper examinations were conducted at any time to validate commitment procedure, State would be held liable to claimant for false imprisonment, negligence and malpractice.”

Bear in mind that patients are considered able to refuse treatment unless a judicial determination of incompetence exists. Clearly, facilities must educate staff on this issue and must provide some guidelines for assessment of competency so that they may determine if a patient is capable of refusing treatment and initiating discharge.

Assessment tools

A good competency tool can be developed so that staff can assess a patient if a request for discharge is initiated. Simon (1992) suggests that for the psychiatric patient, “Evidence of impaired perception, short- and long-term memory problems, impaired judgment, language comprehension difficulties, and distortions of reality and orientation all will have a bearing on whether a person is cognitively capable of making valid medical decisions.”

A worksheet that enables clinicians to conduct a brief mental status exam and ask a few questions about the patient’s comprehension of the illness and possible consequences of leaving would serve the purpose of assessing competency. If competency is questionable, then detention procedures can be initiated. If not, the voluntary patient may refuse treatment. Results of the assessment should, of course, be documented in the record.

Safety

Occasionally, a psychiatric patient will present as competent, but will continue posing a risk to self or others because of impulsivity, verbal threats, or inability to make a safety commitment. Therefore, assessment of safety is the second component in deciding whether to release the patient who wishes to leave AMA.

A patient who is making threats to harm self or others should not be released, and proper detention protocols must be followed to continue the confinement.

Piccinino (1992) states that the best predictor of suicide completion “was found to be previous attempts.” However, a patient who has, in the past, experienced suicidal ideation or engaged in behaviors of self-harm, may have reached a point in treatment whereby an acceptable level of safety has been reached. Clinicians should be observant of behaviors leading up to the discharge request and can take into account the patient’s ability to discuss safety rationally and to commit to continued safety outside the hospital.

According to Simon (1992), “liability for patient suicide typically occurs when a foreseeable suicidal patient is inappropriately discharged or released from the facility.” However, Simon concludes: “As with any allegation of negligence, the threshold issue is the reasonableness of the decision to release the patient or allow the patient’s escape. The standard of reasonableness, however, does not require 100% accuracy or certainty.”

“A mere mistake in diagnosis or judgment is insufficient for liability. Therefore, if reasonable care in observing, evaluating, and treating a patient would not have revealed the patient as suicidal at the time of release, then liability for a patient who later commits suicide will generally not be found.”

Once again, if staff are uncertain about the patient’s safety, proper detention proceedings must be initiated. Physicians must not ask that the patient be “held” indefinitely without being legally detained. This is particularly true of patients with an Axis II diagnosis of Borderline Personality Disorder who may readily engage staff in power struggles over discharge issues. These patients have an uncanny ability to perceive uncertainty regarding facility policies.

In citing Carser, Piccinino (1990) writes, “it is worth noting that staffs generally split according to lines already drawn in response to hospital policies or rules.”

Astute hospital administrators will know that good communication, proper education on legal protocols, and an expectation of professional and ethical conduct from all physicians and nurses will help to reduce staff splitting over
If clinicians decide to prevent a voluntary patient from leaving a facility, proper protocols must be followed within the time limits defined in that state’s laws on detentions.

AMA discharges can sometimes be prevented by expedient treatment that includes involving the patient in goal-setting, adequate patient teaching, and appropriate discharge planning.

Hospital management personnel should be familiar with individual state laws on detention protocols and should assist staff in resolving irregular discharge questions.

Considerations of Future Trends

The emphasis on patient rights is likely to continue into the 21st century. And, as health care resources become increasingly scarce and more expensive, patients will become more educated consumers. They will insist on being active participants in their treatment and will ask to leave facilities that do not meet their needs. Clinicians have an ethical obligation to provide treatment that stabilizes symptoms and includes good discharge planning, rather than extending length of stay unnecessarily.

Hospitals everywhere are already struggling with economic issues. Mental health units are closing or combining, and staffing ratios are changing. All of these factors contribute to an increasingly acute psychiatric milieu, and this kind of environment can lead to an increase in AMAs among voluntary patients.

Nursing leaders must teach their staff how to manage these changes and to develop treatment methods that reflect today’s health care environment. Clinicians must be skilled in assessment of safety and competency, and must understand the law as it pertains to the confinement of both voluntary and involuntary patients.

Mental health home care

A relatively new field of psychiatry, mental health home care, is presenting new challenges around these issues. Patients in home care settings often are seen only by the RN case manager, making that individual independently accountable for that patient’s safety. Treatment refusals that result in discharge must be carefully evaluated, and home care mental health nurses should use clinical supervision and maintain good communication with the physician who has authorized treatment.

In conclusion, patients in all psychiatric settings have a right to refuse treatment or to be discharged AMA. However, it is the obligation of health care providers to assess their safety and competency and to use legal protocols for confinement if safety or competency criteria are not met.

References

Cook v. Highland Hospital, 84 S.E. 352 (N.C. 1915).
Hapgood v. Biloxi Regional Medical Center, 540 So. 2d 630 (Miss. 1989).